Exhibit A

Name	health_survey.html
File Ext	html
Description	File
Is Deleted	NO
Last Accessed	05/24/99 11:38:50
File Created	05/24/99 11:38:48
Last Written	05/24/99 11:38:50
Entry Modified	
Logical Size	3,734
Full Path	BH2653148A01\001\WINDOWS\Temporary Internet Files\6WF1DXNN\health_survey.html

Name	health_survey1.html
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Description	File
Is Deleted	NO
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Last Written	05/24/99 11:38:56
Entry Modified	
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Full Path	BH2653148A01\001\WINDOWS\Temporary Internet Files\ZBMZHO7W\health_survey1.html

Exhibit B

Name	health_survey.html
File Ext	html
Description	File
Is Deleted	NO
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Name	health_survey1.html
File Ext	html
Description	File
Is Deleted	NO
Last Accessed	05/24/99 11:38:56
File Created	05/24/99 11:38:54
Last Written	05/24/99 11:38:56
Entry Modified	
Logical Size	11,970
Full Path	BH2653148A02\001\WINDOWS\Temporary Internet Files\ZBMZHO7W\health_survey1.html

Exhibit C

Name health_survey.html
Full Path BH2653148A01\001\WINDOWS\Temporary Internet Files\6WF1DXNN\health_survey.html

```
<HTML>
<HEAD><TITLE>The Body: Volunteer for Research!</TITLE></HEAD>

<BODY BGCOLOR="#FFFFFF" LINK="#FF0000">

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<TR VALIGN=TOP>

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ogo" BORDER=0></A>
</TD>

<TD ROWSPAN=10>
<IMG WIDTH=1 HEIGHT=1 HSPACE=10 SRC="../images/dotclear.gif">
</TD>

<TD VALIGN=MIDDLE>
<H2>Volunteer for Research!</H2>
</TD>

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<B><FONT SIZE="-1"><A HREF="health_remove.ihtml">Please remove my name as a volunteer</A><BR></F
ONT></B>
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<!--end of nested table for remove link-->

<P><BR>

<IMG SRC="images/smiling_doc.jpg" WIDTH=150 HEIGHT=225 BORDER=0 ALT="smiling doctor">

<P><BR><BR>

<IMG SRC="images/microscope.jpg" WIDTH=150 HEIGHT=225 BORDER=0 ALT="microscope">

<P><BR><BR>

<IMG SRC="images/beakers.jpg" WIDTH=225 HEIGHT=150 BORDER=0 ALT="beakers">

</TD>

<TD WIDTH=250>

<I>The Body</I> is compiling a database of volunteers' health information for possible participa
tion in upcoming medical trials.  Clinical researchers and labs often contact <I>The Body</I> fo
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<P>After you complete the Health Survey and transmit it to <I>The Body</I>, your information wil
l be sorted and stored in <I>The Body</I>'s database. <I>The Body</I> will provide your informat
ion upon an appropriate request from a lab or researcher.  If the lab or researcher agrees that
you may be suited for their clinical trial, they may contact you for further information. All re
sponses to the Health Survey will be encrypted during transmission using technology built in to
most modern browsers and stored securely on our server. Furthermore, all of the data we collect
is protected against unauthorized access. Older browsers may not support some aspects of the thi
s technology, or may offer weakened versions of it. To better protect your privacy, we suggest y
ou <A HREF="health_secure.html" NAME="back">upgrade to the most recent version of your browser</
A> and <A HREF="health_secure.html">verify you are communicating securely with <I>The Body</I></
A>.

<P>Prior to completing the Health Survey, please take a moment to read the information regarding
 the Health Survey on the following page.  In order to participate you must first agree to the t
erms and conditions set forth on the following page and consent to the release to others of the
health information you will be providing, particularly your HIV status.

<P ALIGN=CENTER><A HREF="health_survey1.ihtml"><IMG SRC="images/proceed_button.gif" WIDTH=72 HEI
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/connect.shtml"><IMG WIDTH=70 HEIGHT=97 SRC="../images/navconn.gif" BORDER=0></A><A HREF="../exp
erts.shtml"><IMG WIDTH=70 HEIGHT=97 SRC="../images/navins.gif" BORDER=0></A><A HREF="../govt.htm
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IDTH=67 HEIGHT=97 SRC="../images/navhelp.gif" BORDER=0></A><A HREF="../index.shtml#search"><IMG
WIDTH=67 HEIGHT=97 SRC="../images/navsearch.gif" BORDER=0></A>
</DIV>

</BODY>
</HTML>
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Exhibit D

Name health_survey1.html
Full Path BH2653148A01\001\WINDOWS\Temporary Internet Files\ZBMZHO7W\health_survey1.html

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<BODY BGCOLOR="#FFFFFF" LINK="#FF0000">

<TABLE BORDER=0 CELLSPACING=0 CELLPADDING=0>
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ogo" BORDER=0></A>

</TD>

<TD ROWSPAN=10>
<IMG WIDTH=1 HEIGHT=1 HSPACE=10 SRC="../images/dotclear.gif">
</TD>

<TD VALIGN=MIDDLE>
<H2>Volunteer for Research!</H2>
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</TR>

<TR>
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<P><BR>

<!--nested table for remove option-->
<TABLE BORDER=0 CELLPADDING=8>
<TR>
<TD WIDTH=150 BGCOLOR="#CCCCFF">
<B><FONT SIZE="-1">You must click on the "<A HREF="#I_Accept">I Accept</A>" button below to proc
eed with the Health Survey.  Please take time to carefully read the Participation Agreement you
will be signing.<BR></FONT></B>
</TD>
</TR>
</TABLE>
<!--end of nested table for remove option-->
</TD>

<TD WIDTH=350>

<P><BR>

<H3>Participation Agreement<BR>
May 24, 1999 </H3>

<P>This Participation Agreement is entered into between you and Body Health Resources Corporatio
n (<I>The Body</I>) for the purposes and under the terms and conditions described below.

<P><B>Voluntary Nature</B>. You may contribute information about your health to <I>The Body</I>.
 Your decision to provide this information is completely voluntary. Providing health information
 to <I>The Body</I> via the Health Survey is not required to obtain any information from <I>The
Body</I>. You must be at least 18 years of age to fill out the Health Survey, and the decision t
o submit information to <I>The Body</I> must be yours alone.

<P><B>Referral to Clinical Trials</B>. <I>The Body</I> may provide clinical researchers and labs
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with your information in the Health Survey, although <I>The Body</I> does not guarantee that it will provide your information to any clinical researchers nor does <I>The Body</I> guarantee th at any clinical researcher will contact you as a result of <I>The Body</I>'s providing your info rmation to it. <I>The Body</I> may also provide your information to third-party technology provi ders as a means of transmitting and storing your information.

<P><B>Confidentiality</B>. <I>The Body</I> will take precautions to maintain the confidentiality of your responses to the Health Survey, including encrypting all transmissions that include the responses you provide. Nevertheless, precautions can fail. <I>The Body</I> and its independent, third-party technology providers can not guarantee that encryption technologies are undeciphera ble, or that so-called "secure" servers on or off <I>The Body</I>'s premises are impenetrable to those without authorized access, or that all the individuals handling this information will be medical personnel, or indeed that no individual handling this information will misappropriate it . We try, within reason, to minimize those possibilities, but those are all risks you take in su bmitting the Health Survey.

<P><B>Limitation of Liability</B>. <I>The Body</I> further specifically disclaims liability for unauthorized interception or infiltration of data you submit, and for misappropriation of your d ata by third parties or employees of technology providers. Moreover, we can make no assurances f or the times your data will be out of our direct control, during both transmission and storage.

<P><B>Compensation and Ownership Rights</B>. You will not be compensated in any way for providin g this information to <I>The Body</I> nor do you have any ownership or other rights in any studi es that you may be asked to join or in anything derived from such studies.

<P><B>Independence of Clinical Trials</B>. <I>The Body</I> is not affiliated with any clinical t rial or study nor does <I>The Body</I> evaluate, approve, review or endorse any studies or any u se of the information provided to such studies. <I>The Body</I> does not control or determine ho w information provided to any clinical trial or study is used or whether these clinical trials w ill provide such information to others with which it has agreements.

<P><B>Informed Consent</B>. Completing and sending the Health Survey to <I>The Body</I> in no wa y means that you are giving informed consent for a study. If you are selected to be a part of a clinical trial, you will then be asked at that point to give informed consent to such clinical trial. The Health Survey is neither an advertisement for clinical studies in general nor an adve rtisement for any specific clinical study. The sole purpose of the Health Survey is to enable < I>The Body</I> to possibly match your medical profile with appropriate clinical studies that, ac cording to your responses in the Health Survey, you may be suited for.

<P><B><A NAME="authorization">Authorization</A></B>. You authorize <I>The Body</I> to release an y and all health information, including all HIV-related health information, that you provide in the Health Survey to various clinical researchers and laboratories that <I>The Body</I> determin es, in its sole and absolute discretion, may be able to utilize your information to match your m edical profile with clinical tests and studies. The purpose of this authorization is to provide your health information, including your HIV-related health information, to various clinical res earchers and laboratories via <I>The Body</I> so that such researchers and laboratories can eval uate your suitability for clinical tests and studies. You also authorize <I>The Qž^V····ðÝBody< /I> to release this information to third-party technology providers that <I>The Body</I> deems s uitable, in its sole and absolute discretion, for the purpose of storing your health information and transmitting it to clinical researchers and laboratories. Furthermore, you agree that by c licking on the "I Accept" button below and transmitting
this Release to <I>The Body</I> that your acceptance and transmission shall have the same force and effect as if you had manually signed a written authorization and release. This Release shall be effective for a perpetual duration, but <A HREF="health_remove.ihtml">you may subsequently r equest that <I>The Body</I> no longer provide information to clinical researchers</A>.

<P><B>Governing Law/Availability</B>. You agree that this Participation Agreement will be govern ed by the laws of New York, without reference to choice of law rules. By accepting this Particip ation Agreement, you represent that you are a citizen or permanent resident of the United States .

<P><B>Additional Information Relating to Release Under New York Law</B>

<OL>
<P><LI>HIV is the Human Immunodeficiency Virus that causes AIDS.

<P><LI>Confidential HIV related information is any information indicating that a person had an H IV related test, or has HIV infection, HIV-related illness or AIDS, or any information which cou

ld indicate that a person has been potentially exposed to HIV.

<P><LI>In certain situations, New York State Law provides that, except for certain people, confi dential HIV related information can only be given to persons you allow to have it by signing a r elease. You can see a <A HREF="#list">list of people who can be given confidential HIV-related i nformation</A> under that law without a release form.

<P><LI>If you sign this Participation Agreement by clicking on the "I Accept" button, HIV relate d information can be given to <A HREF="#authorization">the people listed above</A>, and for <A H REF="#authorization">the reason(s) listed above</A>. You do not have to sign this Participation Agreement. You can go back and change your mind at any time before or after you submit the Parti cipation Agreement by filling out the <A HREF="health_remove.ihtml">removal form</A>.

<P><LI>If you experience discrimination because of release of HIV-related information, you may c ontact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commis sion of Human Rights at (212) 566-5493. These agencies are responsible for protecting any right s you may have under New York law.

<P><LI>For questions about this form, contact <A HREF="mailto:research@thebody.com">research@the body.com</A>. Your clicking the "I Accept" button at the bottom of this Participation Agreement will indicate that your questions about this form have been answered. It further indicates that you know that you do not have to allow release of HIV-related information, and that you can cha nge your mind at any time before or after you submit the form.
</OL>

<P><B><A NAME="list">The following is a list of people who may be given confidential HIV informa tion under New York law, without a release form:</A></B>

<P>New York State law protects HIV-related information, including HIV test results, from being d isclosed by health and social service providers without the patient's consent. By law, giving H IV information about you without your consent or testing you for HIV without your written consen t may be punished by a fine of up to $5,000 and a jail term of up to one year.

<P>In the law, there are some exceptions that give your health care providers permission to shar e HIV information about you without your written consent. These include:

<OL>
<P><LI>Medical professionals treating you or your child may discuss your HIV information with ea ch other or with their supervisors, but only in order to provide necessary care for you or your child;

<P><LI>A hospital or other health care provider may share HIV information with your insurance co mpany if the information is necessary to pay for your medical care;

<P><LI>A physician may inform your sexual or needle-sharing contacts without giving your identif y and only after informing you of his/her intent to do so;

<P><LI>A committee, organization or government agency, when it needs such information to supervi se, monitor or administer a health or social service may have access to this information;

<P><LI>Agencies or prospective adoptive or foster parents for foster care or adoption purposes m ay have access to this information;

<P><LI>A Federal, State, county, or local health officer may have access to this information whe n State or Federal law requires disclosure;

<P><LI>If you are a minor, your parent or guardian can be told HIV-related information bout you if it is necessary to provide timely care for you, unless it would not be in your best interest to do so;

<P><LI>Any person to whom a court orders disclosure may have access to this information;

<P><LI>Medical personnel and certain other supervisory staff may have access to your HIV informa tion in order to provide services to you or to monitor services, if you are in jail or prison, o r on parole.
</OL>

<P>By clicking on the "I accept" button below, I hereby agree to the terms and conditions of thi

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s Participation Agreement immediately set forth above.

<P>

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ent resident of the U.S."></A>

<P>

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Exhibit E

Name health_survey.html
Full Path BH2653148A02\001\WINDOWS\Temporary Internet Files\6WF1DXNN\health_survey.html

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<H2>Volunteer for Research!</H2>
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</TR>

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</TR>
</TABLE>
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<P><BR>

<IMG SRC="images/smiling_doc.jpg" WIDTH=150 HEIGHT=225 BORDER=0 ALT="smiling doctor">

<P><BR><BR>

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IDTH=67 HEIGHT=97 SRC="../images/navhelp.gif" BORDER=0></A><A HREF="../index.shtml#search"><IMG
WIDTH=67 HEIGHT=97 SRC="../images/navsearch.gif" BORDER=0></A>
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Exhibit F

Name health_survey1.html
Full Path BH2653148A02\001\WINDOWS\Temporary Internet Files\ZBMZHO7W\health_survey1.html

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<TD ROWSPAN=10>
<IMG WIDTH=1 HEIGHT=1 HSPACE=10 SRC="../images/dotclear.gif">
</TD>

<TD VALIGN=MIDDLE>
<H2>Volunteer for Research!</H2>
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<TD WIDTH=350>

<P><BR>

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May 24, 1999 </H3>

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<P><B>Limitation of Liability</B>. <I>The Body</I> further specifically disclaims liability for unauthorized interception or infiltration of data you submit, and for misappropriation of your d ata by third parties or employees of technology providers. Moreover, we can make no assurances f or the times your data will be out of our direct control, during both transmission and storage.

<P><B>Compensation and Ownership Rights</B>. You will not be compensated in any way for providin g this information to <I>The Body</I> nor do you have any ownership or other rights in any studi es that you may be asked to join or in anything derived from such studies.

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<P><B><A NAME="authorization">Authorization</A></B>. You authorize <I>The Body</I> to release an y and all health information, including all HIV-related health information, that you provide in the Health Survey to various clinical researchers and laboratories that <I>The Body</I> determin es, in its sole and absolute discretion, may be able to utilize your information to match your m edical profile with clinical tests and studies. The purpose of this authorization is to provide your health information, including your HIV-related health information, to various clinical res earchers and laboratories via <I>The Body</I> so that such researchers and laboratories can eval uate your suitability for clinical tests and studies. You also authorize <I>The Body</I> to rel ease this information to third-party technology providers that <I>The Body</I> deems suitable, i n its sole and absolute discretion, for the purpose of storing your health information and trans mitting it to clinical researchers and laboratories. Furthermore, you agree that by clicking on the "I Accept" button below and transmitting
this Release to <I>The Body</I> that your acceptance and transmission shall have the same force and effect as if you had manually signed a written authorization and release. This Release shall be effective for a perpetual duration, but <A HREF="health_remove.ihtml">you may subsequently r equest that <I>The Body</I> no longer provide information to clinical researchers</A>.

<P><B>Governing Law/Availability</B>. You agree that this Participation Agreement will be govern ed by the laws of New York, without reference to choice of law rules. By accepting this Particip ation Agreement, you represent that you are a citizen or permanent resident of the United States .

<P><B>Additional Information Relating to Release Under New York Law</B>

<OL>
<P><LI>HIV is the Human Immunodeficiency Virus that causes AIDS.

<P><LI>Confidential HIV related information is any information indicating that a person had an H IV related test, or has HIV infection, HIV-related illness or AIDS, or any information which cou

ld indicate that a person has been potentially exposed to HIV.

<P><LI>In certain situations, New York State Law provides that, except for certain people, confi dential HIV related information can only be given to persons you allow to have it by signing a r elease. You can see a <A HREF="#list">list of people who can be given confidential HIV-related i nformation</A> under that law without a release form.

<P><LI>If you sign this Participation Agreement by clicking on the "I Accept" button, HIV relate d information can be given to <A HREF="#authorization">the people listed above</A>, and for <A H REF="#authorization">the reason(s) listed above</A>. You do not have to sign this Participation Agreement. You can go back and change your mind at any time before or after you submit the Parti cipation Agreement by filling out the <A HREF="health_remove.ihtml">removal form</A>.

<P><LI>If you experience discrimination because of release of HIV-related information, you may c ontact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commis sion of Human Rights at (212) 566-5493. These agencies are responsible for protecting any right s you may have under New York law.

<P><LI>For questions about this form, contact <A HREF="mailto:research@thebody.com">research@the body.com</A>. Your clicking the "I Accept" button at the bottom of this Participation Agreement will indicate that your questions about this form have been answered. It further indicates that you know that you do not have to allow release of HIV-related information, and that you can cha nge your mind at any time before or after you submit the form.
</OL>

<P><B><A NAME="list">The following is a list of people who may be given confidential HIV informa tion under New York law, without a release form:</A></B>

<P>New York State law protects HIV-related information, including HIV test results, from being d isclosed by health and social service providers without the patient's consent. By law, giving H IV information about you without your consent or testing you for HIV without your written consen t may be punished by a fine of up to $5,000 and a jail term of up to one year.

<P>In the law, there are some exceptions that give your health care providers permission to shar e HIV information about you without your writw¿<P····ðÿten consent. These include:

<OL>
<P><LI>Medical professionals treating you or your child may discuss your HIV information with ea ch other or with their supervisors, but only in order to provide necessary care for you or your child;

<P><LI>A hospital or other health care provider may share HIV information with your insurance co mpany if the information is necessary to pay for your medical care;

<P><LI>A physician may inform your sexual or needle-sharing contacts without giving your identif y and only after informing you of his/her intent to do so;

<P><LI>A committee, organization or government agency, when it needs such information to supervi se, monitor or administer a health or social service may have access to this information;

<P><LI>Agencies or prospective adoptive or foster parents for foster care or adoption purposes m ay have access to this information;

<P><LI>A Federal, State, county, or local health officer may have access to this information whe n State or Federal law requires disclosure;

<P><LI>If you are a minor, your parent or guardian can be told HIV-related information bout you if it is necessary to provide timely care for you, unless it would not be in your best interest to do so;

<P><LI>Any person to whom a court orders disclosure may have access to this information;

<P><LI>Medical personnel and certain other supervisory staff may have access to your HIV informa tion in order to provide services to you or to monitor services, if you are in jail or prison, o r on parole.
</OL>

<P>By clicking on the "I accept" button below, I hereby agree to the terms and conditions of thi

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s Participation Agreement immediately set forth above.

<P>

<DIV ALIGN="center">
<a name="I_Accept"><a href="https://www.thebody.com/surveys/health_survey2a.ihtml?submit=1"><Img
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ent resident of the U.S."></A>

<P>

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</BODY>
</HTML>
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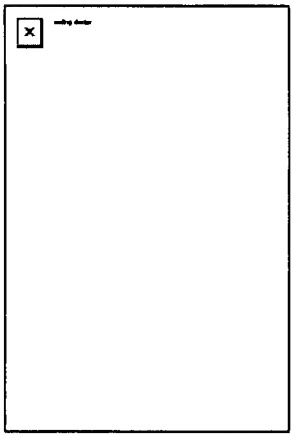
Exhibit G

Name health_survey.html
Full Path BH2653148A01\001\WINDOWS\Temporary Internet Files\6WF1DXNN\health_survey.html

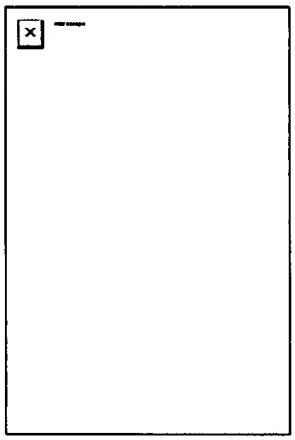
Volunteer for Research!

The Body is compiling a database of volunteers' health information for possible participation in upcoming medical trials. Clinical researchers and labs often contact *The Body* for information regarding volunteers for participation in various clinical trials and studies, and *The Body* is building this database for the purpose of facilitating such requests. Currently, this program is available only to citizens and permanent residents of the United States.

Please remove my name as a volunteer

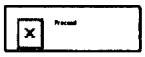


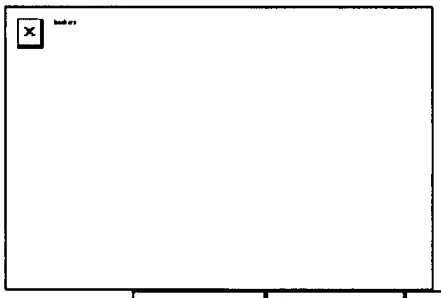
After you complete the Health Survey and transmit it to *The Body*, your information will be sorted and stored in *The Body*'s database. *The Body* will provide your information upon an appropriate request from a lab or researcher. If the lab or researcher agrees that you may be suited for their clinical trial, they may contact you for further information. All responses to the Health Survey will be encrypted during transmission using technology built in to most modern browsers and stored securely on our server. Furthermore, all of the data we collect is protected against unauthorized access. Older browsers may not support some aspects of the this technology, or may offer weakened versions of it. To better protect your privacy, we suggest you upgrade to the most recent version of your browser and verify you are communicating securely with *The*



Body.

Prior to completing the Health Survey, please take a moment to read the information regarding the Health Survey on the following page. In order to participate you must first agree to the terms and conditions set forth on the following page and consent to the release to others of the health information you will be providing, particularly your HIV status.





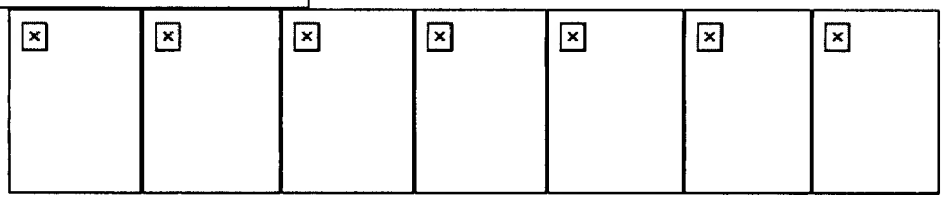


Exhibit H

Name health_survey1.html
Full Path BH2653148A01\001\WINDOWS\Temporary Internet Files\ZBMZHO7W\health_survey1.html

Volunteer for Research!

You must click on the "I Accept" button below to proceed with the Health Survey. Please take time to carefully read the Participation Agreement you will be signing.

Participation Agreement
May 24, 1999

This Participation Agreement is entered into between you and Body Health Resources Corporation (*The Body*) for the purposes and under the terms and conditions described below.

Voluntary Nature. You may contribute information about your health to *The Body*. Your decision to provide this information is completely voluntary. Providing health information to *The Body* via the Health Survey is not required to obtain any information from *The Body*. You must be at least 18 years of age to fill out the Health Survey, and the decision to submit information to *The Body* must be yours alone.

Referral to Clinical Trials. *The Body* may provide clinical researchers and labs with your information in the Health Survey, although *The Body* does not guarantee that it will provide your information to any clinical researchers nor does *The Body* guarantee that any clinical researcher will contact you as a result of *The Body*'s providing your information to it. *The Body* may also provide your information to third-party technology providers as a means of transmitting and storing your information.

Confidentiality. *The Body* will take precautions to maintain the confidentiality of your responses to the

Health Survey, including encrypting all transmissions that include the responses you provide. Nevertheless, precautions can fail. *The Body* and its independent, third-party technology providers can not guarantee that encryption technologies are undecipherable, or that so-called "secure" servers on or off *The Body*'s premises are impenetrable to those without authorized access, or that all the individuals handling this information will be medical personnel, or indeed that no individual handling this information will misappropriate it. We try, within reason, to minimize those possibilities, but those are all risks you take in submitting the Health Survey.

Limitation of Liability. *The Body* further specifically disclaims liability for unauthorized interception or infiltration of data you submit, and for misappropriation of your data by third parties or employees of technology providers. Moreover, we can make no assurances for the times your data will be out of our direct control, during both transmission and storage.

Compensation and Ownership Rights. You will not be compensated in any way for providing this information to *The Body* nor do you have any ownership or other rights in any studies that you may be asked to join or in anything derived from such studies.

Independence of Clinical Trials. *The Body* is not affiliated with any clinical trial or study nor does *The Body* evaluate, approve, review or endorse any studies or any use of the information provided to such studies. *The Body* does not control or determine how information provided to any clinical trial or study is used or whether these clinical trials will provide such information to others with which it has agreements.

Informed Consent. Completing and sending the Health Survey to *The Body* in no way means that you are giving informed consent for a study. If you are selected to be a part of a clinical trial, you will then be asked at that point to give informed consent to such

clinical trial. The Health Survey is neither an advertisement for clinical studies in general nor an advertisement for any specific clinical study. The sole purpose of the Health Survey is to enable *The Body* to possibly match your medical profile with appropriate clinical studies that, according to your responses in the Health Survey, you may be suited for.

Authorization. You authorize *The Body* to release any and all health information, including all HIV-related health information, that you provide in the Health Survey to various clinical researchers and laboratories that *The Body* determines, in its sole and absolute discretion, may be able to utilize your information to match your medical profile with clinical tests and studies. The purpose of this authorization is to provide your health information, including your HIV-related health information, to various clinical researchers and laboratories via *The Body* so that such researchers and laboratories can evaluate your suitability for clinical tests and studies. You also authorize *The Qž^V öÿBody* to release this information to third-party technology providers that *The Body* deems suitable, in its sole and absolute discretion, for the purpose of storing your health information and transmitting it to clinical researchers and laboratories. Furthermore, you agree that by clicking on the "I Accept" button below and transmitting this Release to *The Body* that your acceptance and transmission shall have the same force and effect as if you had manually signed a written authorization and release. This Release shall be effective for a perpetual duration, but you may subsequently request that *The Body* no longer provide information to clinical researchers.

Governing Law/Availability. You agree that this Participation Agreement will be governed by the laws of New York, without reference to choice of law rules. By accepting this Participation Agreement, you represent that you are a citizen or permanent resident of the United States.

Additional Information Relating to Release Under

New York Law

1. HIV is the Human Immunodeficiency Virus that causes AIDS.
2. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV-related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.
3. In certain situations, New York State Law provides that, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can see a list of people who can be given confidential HIV-related information under that law without a release form.
4. If you sign this Participation Agreement by clicking on the "I Accept" button, HIV related information can be given to the people listed above, and for the reason(s) listed above. You do not have to sign this Participation Agreement. You can go back and change your mind at any time before or after you submit the Participation Agreement by filling out the removal form.
5. If you experience discrimination because of release of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting any rights you may have under New York law.
6. For questions about this form, contact research@thebody.com. Your clicking the "I Accept" button at the bottom of this Participation Agreement will indicate that your questions about this form have been answered. It further indicates that you know that you do not have to allow release of HIV-related information, and that you can change your mind at any time before or after you submit the form.

The following is a list of people who may be given confidential HIV information under New York law, without a release form:

New York State law protects HIV-related information, including HIV test results, from being disclosed by health and social service providers without the patient's consent. By law, giving HIV information about you without your consent or testing

you for HIV without your written consent may be punished by a fine of up to $5,000 and a jail term of up to one year.

In the law, there are some exceptions that give your health care providers permission to share HIV information about you without your written consent. These include:

1. Medical professionals treating you or your child may discuss your HIV information with each other or with their supervisors, but only in order to provide necessary care for you or your child;
2. A hospital or other health care provider may share HIV information with your insurance company if the information is necessary to pay for your medical care;
3. A physician may inform your sexual or needle-sharing contacts without giving your identify and only after informing you of his/her intent to do so;
4. A committee, organization or government agency, when it needs such information to supervise, monitor or administer a health or social service may have access to this information;
5. Agencies or prospective adoptive or foster parents for foster care or adoption purposes may have access to this information;
6. A Federal, State, county, or local health officer may have access to this information when State or Federal law requires disclosure;
7. If you are a minor, your parent or guardian can be told HIV-related information bout you if it is necessary to provide timely care for you, unless it would not be in your best interest to do so;
8. Any person to whom a court orders disclosure may have access to this information;
9. Medical personnel and certain other supervisory staff may have access to your HIV information in order to provide services to you or to monitor services, if you are in jail or prison, or on parole.

By clicking on the "I accept" button below, I hereby agree to the terms and conditions of this Participation Agreement immediately set forth above.

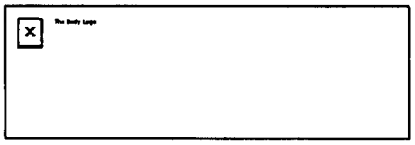
☒

☒ I am not a citizen or permanent resident of the U.S.

☒	☒	☒	☒	☒	☒	☒

Exhibit I

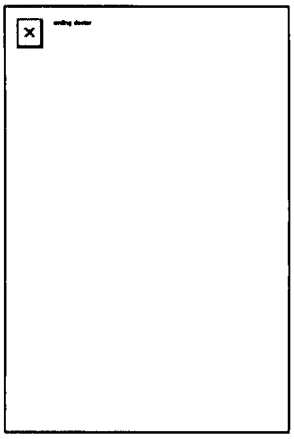
Name health_survey.html
Full Path BH2653148A02\001\WINDOWS\Temporary Internet Files\6WF1DXNN\health_survey.html



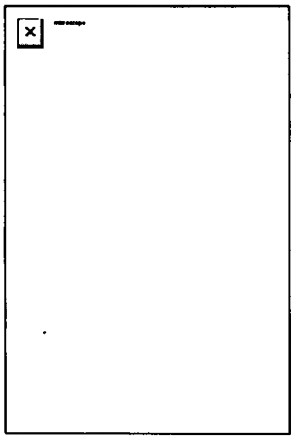
Volunteer for Research!

The Body is compiling a database of volunteers' health information for possible participation in upcoming medical trials. Clinical researchers and labs often contact *The Body* for information regarding volunteers for participation in various clinical trials and studies, and *The Body* is building this database for the purpose of facilitating such requests. Currently, this program is available only to citizens and permanent residents of the United States.

Please remove my name as a volunteer



After you complete the Health Survey and transmit it to *The Body*, your information will be sorted and stored in *The Body*'s database. *The Body* will provide your information upon an appropriate request from a lab or researcher. If the lab or researcher agrees that you may be suited for their clinical trial, they may contact you for further information. All responses to the Health Survey will be encrypted during transmission using technology built in to most modern browsers and stored securely on our server. Furthermore, all of the data we collect is protected against unauthorized access. Older browsers may not support some aspects of the this technology, or may offerßÀ*P öÿ weakened versions of it. To better protect your privacy, we suggest you upgrade to the most recent version of your browser and verify you are communicating securely with *The*



Body.

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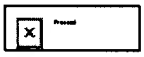

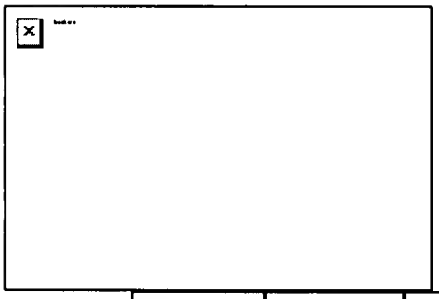

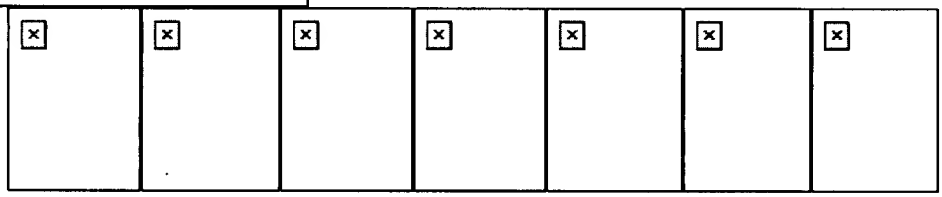

Exhibit J

Name health_survey1.html
Full Path BH2653148A02\001\WINDOWS\Temporary Internet Files\ZBMZHO7W\health_survey1.html

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Participation Agreement
May 24, 1999

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Confidentiality. *The Body* will take precautions to maintain the confidentiality of your responses to the

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Limitation of Liability. *The Body* further specifically disclaims liability for unauthorized interception or infiltration of data you submit, and for misappropriation of your data by third parties or employees of technology providers. Moreover, we can make no assurances for the times your data will be out of our direct control, during both transmission and storage.

Compensation and Ownership Rights. You will not be compensated in any way for providing this information to *The Body* nor do you have any ownership or other rights in any studies that you may be asked to join or in anything derived from such studies.

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4. If you sign this Participation Agreement by clicking on the "I Accept" button, HIV related information can be given to the people listed above, and for the reason(s) listed above. You do not have to sign this Participation Agreement. You can go back and change your mind at any time before or after you submit the Participation Agreement by filling out the removal form.
5. If you experience discrimination because of release of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting any rights you may have under New York law.
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you for HIV without your written consent may be punished by a fine of up to $5,000 and a jail term of up to one year.

In the law, there are some exceptions that give your health care providers permission to share HIV information about you without your writw¿öÿten consent. These include:

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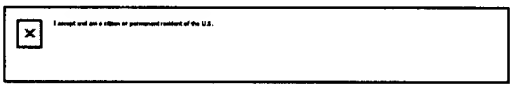
2. A hospital or other health care provider may share HIV information with your insurance company if the information is necessary to pay for your medical care;
3. A physician may inform your sexual or needle-sharing contacts without giving your identify and only after informing you of his/her intent to do so;
4. A committee, organization or government agency, when it needs such information to supervise, monitor or administer a health or social service may have access to this information;
5. Agencies or prospective adoptive or foster parents for foster care or adoption purposes may have access to this information;
6. A Federal, State, county, or local health officer may have access to this information when State or Federal law requires disclosure;
7. If you are a minor, your parent or guardian can be told HIV-related information bout you if it is necessary to provide timely care for you, unless it would not be in your best interest to do so;
8. Any person to whom a court orders disclosure may have access to this information;
9. Medical personnel and certain other supervisory staff may have access to your HIV information in order to provide services to you or to monitor services, if you are in jail or prison, or on parole.

By clicking on the "I accept" button below, I hereby agree to the terms and conditions of this Participation Agreement immediately set forth above.



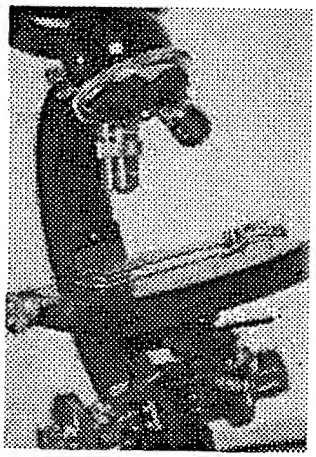
☒ I am not a citizen or permanent resident of the U.S.

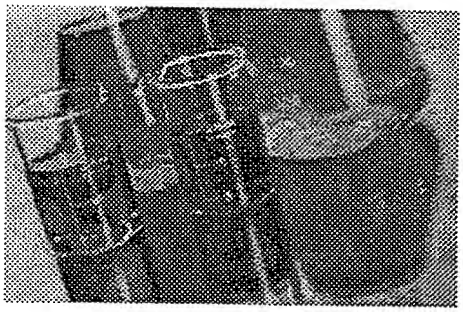
☒	☒	☒	☒	☒	☒	☒

EXHIBIT A

THE BODY

Volunteer for Research!





Studies are conducted to test new treatments. These treatments are often anti-HIV drugs like AZT and protease inhibitors, but many new drugs are being developed and tested to treat other aspects of HIV disease like fatigue, wasting, and neuropathy. So even if your current treatment program is working well, there may be therapies available to you through clinical trials for other aspects of HIV. And even if your anti-retroviral treatment is currently successful, there may be trials for new anti-retroviral drugs that you can participate in without stopping your current regimen. Some trials require that you stop your current treatment, but others allow for you to take the experimental drug with the medications you are already taking.

The Body is compiling a database of volunteers' health information for possible participation in upcoming medical trials. Clinical researchers and labs often contact *The Body*; so do volunteers looking to participate in clinical trials and studies. *The Body* is building this database for the purpose of facilitating such requests. Currently, this program is available only to citizens and permanent residents of the United States.

After you complete the Health

What do you have to gain -- or lose -- by entering a clinical trial? For some people with HIV, there are real advantages to participation. For others, the benefits are not so clear. Check out Clinical Trials: The Basics for helpful guidelines that can make your decision easier.

At any time, you can remove your name from the database of volunteers.

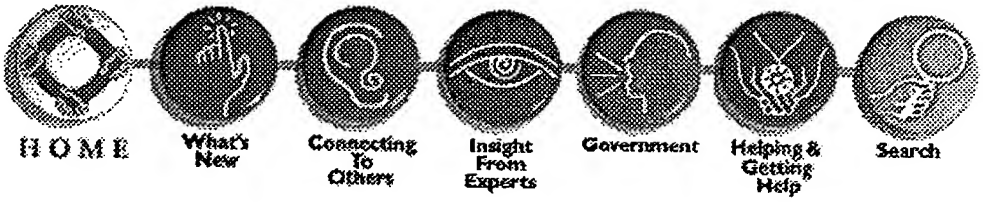
After you complete the Health Survey and transmit it to *The Body*, your information will be sorted and stored in *The Body*'s database. *The Body* will provide your information upon an appropriate request from a lab or researcher. If the lab or researcher agrees that you may be suited for their clinical trial, they may contact you for further information. All responses to the Health Survey will be encrypted during transmission using technology built in to most modern browsers and stored securely on our server. Furthermore, all of the data we collect is protected against unauthorized access. Older browsers may not support some aspects of the this technology, or may offer weakened versions of it. To better protect your privacy, we suggest you upgrade to the most recent version of your browser and verify you are communicating securely with *The Body*.

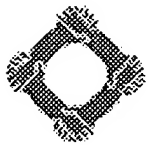
Prior to completing the Health Survey, please take a moment to read the information regarding the Health Survey on the following page. In order to participate you must first agree to the terms and conditions set forth on the following page and consent to the release to others of the health information you will be providing, particularly your HIV status.

What do you have to gain -- or lose -- by entering a clinical trial? For some people with HIV, there are real advantages to participation. For others, the benefits are not so clear. Check out Clinical Trials: The Basics for helpful guidelines that can make your decision easier.

At any time, you can remove your name from the database of volunteers.

Proceed





Volunteer for Research!

You must click on the "I Accept" button below to proceed with the Health Survey. Please take time to carefully read the Participation Agreement you will be signing.

Participation Agreement
August 11, 1999

This Participation Agreement is entered into between you and Body Health Resources Corporation (*The Body*) for the purposes and under the terms and conditions described below.

Voluntary Nature. You may contribute information about your health to *The Body*. Your decision to provide this information is completely voluntary. Providing health information to *The Body* via the Health Survey is not required to obtain any information from *The Body*. You must be at least 18 years of age to fill out the Health Survey, and the decision to submit information to *The Body* must be yours alone.

Referral to Clinical Trials. *The Body* may provide clinical researchers and labs with your information in the Health Survey, although *The Body* does not guarantee that it will provide your information to any clinical researchers nor does *The Body* guarantee that any clinical researcher will contact you as a result of *The Body*'s providing your information to it. *The Body* may also provide your information to third-party technology providers as a means of transmitting and storing your information.

Confidentiality. *The Body* will take precautions to maintain the confidentiality of your responses to the Health Survey, including encrypting all transmissions that include the responses you provide. Nevertheless, precautions can fail. *The Body* and its independent, third-party technology providers can not guarantee that encryption technologies are undecipherable, or that so-called "secure" servers on or off *The Body*'s premises are impenetrable to those without authorized access, or that all the individuals handling this information will be medical personnel, or indeed that no individual handling this information will misappropriate it. We try, within reason, to minimize those possibilities, but those are all risks you take in

submitting the Health Survey.

Limitation of Liability. *The Body* further specifically disclaims liability for unauthorized interception or infiltration of data you submit, and for misappropriation of your data by third parties or employees of technology providers. Moreover, we can make no assurances for the times your data will be out of our direct control, during both transmission and storage.

Compensation and Ownership Rights. You will not be compensated in any way for providing this information to *The Body* nor do you have any ownership or other rights in any studies that you may be asked to join or in anything derived from such studies.

Independence of Clinical Trials. *The Body* is not affiliated with any clinical trial or study nor does *The Body* evaluate, approve, review or endorse any studies or any use of the information provided to such studies. *The Body* does not control or determine how information provided to any clinical trial or study is used or whether these clinical trials will provide such information to others with which it has agreements.

Informed Consent. Completing and sending the Health Survey to *The Body* in no way means that you are giving informed consent for a study. If you are selected to be a part of a clinical trial, you will then be asked at that point to give informed consent to such clinical trial. The Health Survey is neither an advertisement for clinical studies in general nor an advertisement for any specific clinical study. The sole purpose of the Health Survey is to enable *The Body* to possibly match your medical profile with appropriate clinical studies that, according to your responses in the Health Survey, you may be suited for.

Authorization. You authorize *The Body* to release any and all health information, including all HIV-related health information, that you provide in the Health Survey to various clinical researchers and laboratories that *The Body* determines, in its sole and absolute discretion, may be able to utilize your information to match your medical profile with clinical tests and studies. The purpose of this authorization is to provide your health information, including your

HIV-related health information, to various clinical researchers and laboratories via *The Body* so that such researchers and laboratories can evaluate your suitability for clinical tests and studies. You also authorize *The Body* to release this information to third-party technology providers that *The Body* deems suitable, in its sole and absolute discretion, for the purpose of storing your health information and transmitting it to clinical researchers and laboratories. Furthermore, you agree that by clicking on the "I Accept" button below and transmitting this Release to *The Body* that your acceptance and transmission shall have the same force and effect as if you had manually signed a written authorization and release. This Release shall be effective for a perpetual duration, but you may subsequently request that *The Body* no longer provide information to clinical researchers.

Governing Law/Availability. You agree that this Participation Agreement will be governed by the laws of New York, without reference to choice of law rules. By accepting this Participation Agreement, you represent that you are a citizen or permanent resident of the United States.

Additional Information Relating to Release Under New York Law

1. HIV is the Human Immunodeficiency Virus that causes AIDS.

2. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV-related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

3. In certain situations, New York State Law provides that, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can see a list of people who can be given confidential HIV-related information under that law without a release form.

4. If you sign this Participation Agreement by clicking on the "I Accept" button, HIV related information can be given to the people listed

above, and for the reason(s) listed above. You do not have to sign this Participation Agreement. You can go back and change your mind at any time before or after you submit the Participation Agreement by filling out the removal form.

5. If you experience discrimination because of release of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting any rights you may have under New York law.

6. For questions about this form, contact research@thebody.com. Your clicking the "I Accept" button at the bottom of this Participation Agreement will indicate that your questions about this form have been answered. It further indicates that you know that you do not have to allow release of HIV-related information, and that you can change your mind at any time before or after you submit the form.

The following is a list of people who may be given confidential HIV information under New York law, without a release form:

New York State law protects HIV-related information, including HIV test results, from being disclosed by health and social service providers without the patient's consent. By law, giving HIV information about you without your consent or testing you for HIV without your written consent may be punished by a fine of up to $5,000 and a jail term of up to one year.

In the law, there are some exceptions that give your health care providers permission to share HIV information about you without your written consent. These include:

1. Medical professionals treating you or your child may discuss your HIV information with each other or with their supervisors, but only in order to provide necessary care for you or your child;

2. A hospital or other health care provider may

share HIV information with your insurance company if the information is necessary to pay for your medical care;

3. A physician may inform your sexual or needle-sharing contacts without giving your identify and only after informing you of his/her intent to do so;

4. A committee, organization or government agency, when it needs such information to supervise, monitor or administer a health or social service may have access to this information;

5. Agencies or prospective adoptive or foster parents for foster care or adoption purposes may have access to this information;

6. A Federal, State, county, or local health officer may have access to this information when State or Federal law requires disclosure;

7. If you are a minor, your parent or guardian can be told HIV-related information about you if it is necessary to provide timely care for you, unless it would not be in your best interest to do so;

8. Any person to whom a court orders disclosure may have access to this information;

9. Medical personnel and certain other supervisory staff may have access to your HIV information in order to provide services to you or to monitor services, if you are in jail or prison, or on parole.

By clicking on the "I accept" button below, I hereby agree to the terms and conditions of this Participation Agreement immediately set forth above.

I accept and am a citizen or permanent resident of the U.S.

I am not a citizen or permanent resident of the U.S.

Health Survey

1. How old are you? [ ] years old

2. Please enter your sex:

- ○ I am male
- ○ I am female

3. How would you characterize your health?

- ○ excellent
- ○ good
- ○ fair
- ○ poor

4. How long do you think you have been infected? (Note: The Health Survey focuses on people who are HIV-positive.)

- ○ less than one year
- ○ one to two years
- ○ two to four years
- ○ four to six years
- ○ six to eight years
- ○ more than eight years
- ○ more than 11 years
- ○ I don't know

5. Would you be willing to participate as a subject in a medical research project?

- ○ yes
- ○ no

6. What was your last viral load count?

[ ]

- ○ I don't know

7. What was your last T-Cell count?

- ○ under 100
- ○ 100 to 200
- ○ 200 to 300
- ○ 300 to 400
- ○ 400 to 500
- ○ 500 to 600
- ○ over 600
- ○ I don't know

8. Which HIV antiviral medications are you currently taking? Select as many as apply:

- ☐ 3TC (Lamivudine)
- ☐ Abacavir (Ziagen, formerly 1592U89)
- ☐ Amprenavir (Agenerase)
- ☐ AZT (Zidovudine, ZDV)
- ☐ Combivir (AZT plus 3TC)
- ☐ d4T (Stavudine)
- ☐ ddC (Hivid)
- ☐ ddI (Didanosine)
- ☐ Delavirdine (Rescriptor)
- ☐ Efavirenz (Sustiva, formerly DMP-266)
- ☐ Loviride
- ☐ Nevirapine (Viramune)
- ☐ Indinavir (Crixivan, MK-639)
- ☐ Nelfinavir (Viracept)
- ☐ Ritonavir (Norvir)
- ☐ Saquinavir (Invirase, Fortovase)
- ☐ Other anti-HIV medications (please specify; note that more medications are listed in Question 10)

- ☐ I don't know
- ☐ I am currently not taking any medications

9. Which HIV antiviral medications have you taken in the past? Select as many as apply:

- ☐ 3TC (Lamivudine)
- ☐ Abacavir (Ziagen, formerly 1592U89)

- ☐ Amprenavir (Agenerase)
- ☐ AZT (Zidovudine, ZDV)
- ☐ Combivir (AZT plus 3TC)
- ☐ d4T (Stavudine)
- ☐ ddC (Hivid)
- ☐ ddI (Didanosine)
- ☐ Delavirdine (Rescriptor)
- ☐ Efavirenz (Sustiva, formerly DMP-266)
- ☐ Loviride
- ☐ Nevirapine (Viramune)
- ☐ Indinavir (Crixivan, MK-639)
- ☐ Nelfinavir (Viracept)
- ☐ Ritonavir (Norvir)
- ☐ Saquinavir (Invirase, Fortovase)
- ☐ Other (please specify)

- ☐ I don't know
- ☐ I have never taken any medications for HIV

10. What additional medications are you currently taking? Select as many as apply:

- ☐ Acyclovir (Zovirax)
- ☐ Adefovir (Preveon)
- ☐ Amphotericin B (Fungizone)
- ☐ Atovaquone (Mepron)
- ☐ Azithromycin (Zithromax)
- ☐ Bactrim (TMP/SMX)
- ☐ Cidofovir (Vistide)
- ☐ Ciprofloxacin (Cipro)
- ☐ Clarithromycin (Biaxin)
- ☐ Clindamycin (Cleocin)
- ☐ Clofazimine (Lamprene)
- ☐ Cycloserine (Seromycin)
- ☐ Dapsone
- ☐ Emivirine (MKC-442)
- ☐ Ethambutol
- ☐ Fluconazole (Diflucan)

- ☐ Flucytosine (Ancobon)
- ☐ Fomivirsen (ISIS 2922)
- ☐ Foscarnet (Foscavir)
- ☐ Ganciclovir (Cytovene)
- ☐ Inderal
- ☐ Isoniazid
- ☐ Itraconazole (Sporanox)
- ☐ Leucovorin
- ☐ Pentamidine (aerosolized)
- ☐ Prozac
- ☐ Pyrazinamide
- ☐ Pyrimethamine (Daraprim, Fansidar)
- ☐ Rifabutin (Mycobutin)
- ☐ Rifampin (Rifadin)
- ☐ Rimantadine
- ☐ Sparfloxacin
- ☐ Sulfadiazine
- ☐ Other (please list all other medications you are taking)

- ☐ I am not taking any additional medications

11. Have you ever been diagnosed with any of the following infections or complications? Select as many as apply:

- ☐ Anemia
- ☐ Cancer
- ☐ Candidiasis
- ☐ Cryptococcosis
- ☐ Cryptosporidiosis
- ☐ Cytomegalovirus (CMV)
- ☐ Hepatitis
- ☐ Herpes
- ☐ Kaposi's Sarcoma (KS)
- ☐ Microsporidiosis
- ☐ Mycobacterium avium Complex (MAC)
- ☐ Neuropathy
- ☐ AIDS Dementia

- ☐ PML (Progressive Multifocal Leukoencephalopathy)
- ☐ Other Neurological/Neurocognitive Complications
- ☐ Non-Hodgkins Lymphoma
- ☐ Oral and Esophageal Thrush
- ☐ Pneumocystis carinii Pneumonia (PCP)
- ☐ Sinusitis
- ☐ Toxoplasmosis
- ☐ Tuberculosis
- ☐ Wasting
- ☐ Other (please specify)

☐ I have never been diagnosed with any infection or complication of HIV

12. Can we contact you by e-mail about participating in a clinical research project?

- ○ No
- ○ Yes

If yes, please provide your e-mail address:

13. May we phone you? (Note: To be contacted to participate, you must provide an e-mail address or phone number)

- ○ No
- ○ Yes

If yes, please provide your phone number:
area code number

14. Please provide your name and place of residence.

Last name:

First name:

Place of residence:

City [ ] State [---] Zip Code [ ]

15. In order for us to identify you properly, please give us your birthdate:

Month: [ ] Day: [ ] Year: [ ]

Thank you for taking the time to take this survey. Please note that no one will contact you unless or until there is an appropriate request from a lab or researcher.

[Submit]

The Body Logo

Research Opportunities for Physicians

The Body often receives inquiries from pharmaceutical companies and contract research organizations (CROs) interested in recruiting physician investigators for clinical trials of investigational drugs. In an effort to coordinate physicians interested in participating in clinical research, with researchers conducting studies, *The Body* is compiling a physician database. The information you provide will be shared with pharmaceutical companies and CROs conducting studies. You will be contacted only if it is decided that your patient base and practice arrangement might be amenable to working on a research project.

Thanks so much for taking the time to fill out this survey!

Please note: this application is for physicians only!

Last Name

First Name

Phone

Email

Address of Practice:

Street

Suite #

City

State

Zip Code

Dial

Country

Type of Practice

How many HIV patients do you currently treat?

Doctor with Syringe

How many treatment naïve patients do you start on treatment in a year?

Do you employ or have access to clinical research staff / a research nurse?

- Yes
- No

Does your staff / office have access to the Internet?

- Yes
- No

Do you have clinical research experience?

- Yes
- No

If yes, how many years of experience?

Approximately how many studies?

Submit

THE BODY

An AIDS and HIV Information Resource

e-mail: info@thebody.com
web: http://www.thebody.com

250 West 57 Street, Suite 415
New York, New York 10107-0415

212-541-8500
212-541-4911 facsimile

September 1, 1999

James D. Marks
Body Health Resources Corp.
250 West 57th Street
Suite 415
New York, New York 10107

RE: CLINICAL RESEARCH OPPORTUNITIES

Dear Dr. Marks:

Whether you are already actively involved in clinical research or are newly looking to become a part of HIV drug development, *The Body*, the premier Internet HIV/AIDS resource (www.thebody.com), is developing services that will interest you. The Web is quickly becoming an important platform for research; *The Body's* established relationships with pharmaceutical companies and the site's extensive visitorship have resulted in a number of requests to facilitate clinical trial patient and investigator recruitment. We recently launched a carefully designed, secure area of *The Body* to recruit patients interested in becoming part of clinical studies, and ***we now have a similar area of the site dedicated to physicians interested in clincal research.***

Your leadership in HIV/AIDS and your interest in *The Body* have encouraged us to reach out to you in advance of the general launch of the clinician-specific clinical trials area, to give you an early opportunity to participate.

As you probably know, *The Body* is an award-winning, free information resource for HIV/AIDS that now reaches 200,000 clinicians, patients, researchers and others every month. The site's library of over 30,000 documents compiled from more than 70 HIV/AIDS organizations is updated daily. Through fifteen question and answer forums with leading experts, site visitors learn more about specific areas of treatment and other relevant issues. *The Body* also provides coverage of important HIV/AIDS conferences with news of the latest-breaking developments in research.

So that we can include you in this exciting opportunity, ***would you please fill out the enclosed postcard or visit the physician research area of the site at www.thebody.com/surveys/physicians.html and complete the online registration.*** In the near future we expect to be able to contact you if you may be suitable to participate as an investigator in trials that make use of this unique platform. If you have questions in the meantime please call.

Sincerely,
THE BODY

Dahlia Elsayed
Project Coordinator

DE/ts

P.S.: *The Body* remains the premier HIV/AIDS information and education resource on the Internet. If you have patients who are interested in learning more, the enclosed wallet-sized cards will give them *The Body's* web address.

THE BODY

Research Opportunities for Physicians

The Body often receives inquiries from pharmaceutical companies and contract research organizations (CROs) interested in recruiting physician investigators for clinical trials of investigational drugs. In an effort to coordinate physicians interested in participating in clinical research, with researchers conducting studies, *The Body* is compiling a physician database. The information you provide will be shared with pharmaceutical companies and CROs conducting studies. You will be contacted only if it is decided that your patient base and practice arrangement might be amenable to working on a research project.

Thanks so much for taking the time to fill out this survey!

Last Name

First Name

Phone

Email

Address of Practice:

Street

Suite #

City

State

THE BODY

Physician Researcher Registration

Your leadership in HIV/AIDS and your interest in *The Body* have encouraged us to reach out to you in advance of the general launch of the clinician-specific clinical trials area, to give you an early opportunity to participate.

Please take a moment to fill out this card so that we may be able to include you in future research projects.

Name:		
Name of Practice:	Contact Person:	
Street Address:		
City:	State: Zip:	
Telephone:	Email Address:	
About how many HIV patients do you treat?		
About how many treatment naïve patients do you start on treatment a year?		
Do you employ or have access to clinical research staff or research nurse?	Yes	No
Can you use a central IRB?	Yes	No
Does your office/staff have access to the Internet?	Yes	No
Do you have clinical research experience?	Yes	No
If yes, How many years of experience? _____ Approximately how many studies? _____		